General

Guideline Title

Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management.

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. 47 p. (Clinical guideline; no. 158).

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: National Institute for Health and Clinical Excellence (NICE). Parent-training/education programmes in the management of children with conduct disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 49 p. (Technology appraisal guidance; no. 102).

Recommendations

Major Recommendations

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned the National Collaborating Centre for Mental Health (NCCMH) in partnership with the Social Care Institute for Excellence to develop this guideline (see the "Availability of Companion Documents" field).

The following guidance is based on the best available evidence. The full version of the original guideline document gives details of the methods and the evidence used to develop the guidance.

All recommendations relate to children and young people aged under 18 years unless otherwise specified.

General Principles of Care

Working Safely and Effectively with Children and Young People

Health and social care professionals working with children and young people who present with behaviour suggestive of a conduct disorder, or who have a conduct disorder, should be trained and competent to work with children and young people of all levels of learning ability, cognitive capacity, emotional maturity and development.

Health and social care professionals should ensure that they:

- Can assess capacity and competence, including "Gillick competence", in children and young people of all ages and
- Understand how to apply legislation, including the Children Act (1989), the Mental Health Act (1983; amended 1995 and 2007) and the Mental Capacity Act (2005), in the care and treatment of children and young people.

Health and social care providers should ensure that children and young people:

- Can routinely receive care and treatment from a single team or professional
- Are not passed from one team to another unnecessarily
- Do not undergo multiple assessments unnecessarily[1]

When providing assessment or treatment interventions for children and young people, ensure that the nature and content of the intervention is suitable for the child or young person's developmental level.

Consider children and young people for assessment according to local safeguarding procedures if there are concerns regarding exploitation or self-care, or if they have been in contact with the criminal justice system[1].

Establishing Relationships With Children and Young People and Their Parents or Carers

Be aware that many children and young people with a conduct disorder may have had poor or punitive experiences of care and be mistrustful or dismissive of offers of help as a result.

Develop a positive, caring and trusting relationship with the child or young person and their parents or carers to encourage their engagement with services.

Health and social care professionals working with children and young people should be trained and skilled in:

- Negotiating and working with parents and carers and
- Managing issues relating to information sharing and confidentiality as these apply to children and young people

If a young person is "Gillick competent" ask them what information can be shared before discussing their condition with their parents or carers.

When working with children and young people with a conduct disorder and their parents or carers:

- Make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected
- Be clear with the child or young person and their parents or carers about limits of confidentiality (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others)[1].

When coordinating care and discussing treatment decisions with children and young people and their parents or carers, ensure that:

- Everyone involved understands the purpose of any meetings and why information might need to be shared between services and
- The right to confidentiality is respected throughout the process

Working With Parents and Carers

If parents or carers are involved in the treatment of young people with a conduct disorder, discuss with young people of an appropriate developmental level, emotional maturity and cognitive capacity how they want them to be involved. Such discussions should take place at intervals to take account of any changes in circumstances, including developmental level, and should not happen only once[1].

Be aware that parents and carers of children and young people with a conduct disorder might feel blamed for their child's problems or stigmatised by their contact with services. When offering or providing interventions such as parent training programmes, directly address any concerns they have and set out the reasons for and purpose of the intervention.

Offer parents and carers an assessment of their own needs including:

- Personal, social and emotional support and
- Support in their caring role, including emergency plans and
- Advice on practical matters such as childcare, housing and finances, and help to obtain support

Communication and Information

When communicating with children and young people with a conduct disorder and their parents or carers:

- Take into account the child or young person's developmental level, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems, or delays in language development or social communication difficulties
- Use plain language if possible and clearly explain any clinical language; adjust strategies to the person's language ability, for example, breaking up information, checking back, summarising and recapping
- Check that the child or young person and their parents or carers understand what is being said
- Use communication aids (such as pictures, symbols, large print, braille, different languages or sign language) if needed

When giving information to children and young people with a conduct disorder and their parents or carers, ensure you are:

- Familiar with local and national sources (organisations and websites) of information and/or support for children and young people with a conduct disorder and their parents or carers
- Able to discuss and advise how to access these resources
- Able to discuss and actively support children and young people and their parents or carers to engage with these resources[1]

When communicating with a child or young person use diverse media, including letters, phone calls, emails or text messages, according to their preference[1].

Culture, Ethnicity and Social Inclusion

When working with children and young people with a conduct disorder and their parents or carers:

- Take into account that stigma and discrimination are often associated with using mental health services
- Be respectful of and sensitive to children and young people's gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability
- Be aware of possible variations in the presentation of mental health problems in children and young people of different genders, ages, cultural, ethnic, religious or other diverse backgrounds[1].

When working with children and young people and their parents or carers who have difficulties speaking or reading English:

- Provide and work proficiently with interpreters if needed
- Offer a list of local education providers who can provide English language teaching

Health and social care professionals working with children and young people with a conduct disorder and their parents or carers should have competence in:

- Assessment skills and using explanatory models of conduct disorder for people from different cultural, ethnic, religious or other diverse backgrounds
- Explaining the possible causes of different mental health problems, and care, treatment and support options
- Addressing cultural, ethnic, religious or other differences in treatment expectations and adherence
- Addressing cultural, ethnic, religious or other beliefs about biological, social and familial influences on the possible causes of mental health problems
- Conflict management and conflict resolution[1]

Staff Supervision

Health and social care services should ensure that staff supervision is built into the routine working of the service, is properly resourced within local systems and is monitored. Supervision should:

- Make use of direct observation (for example, recordings of sessions) and routine outcome measures
- Support adherence to the specific intervention
- Focus on outcomes
- Be regular and apply to the whole caseload

Transfer and Discharge

Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in children and young people with a conduct disorder and their parents or carers. Ensure that:

- Such changes, especially discharge and transfer from child and adolescent mental health services (CAMHS) to adult services, are discussed

and planned carefully beforehand with the child or young person and their parents or carers, and are structured and phased
- Children and young people and their parents or carers are given comprehensive information about the way adult services work and the nature of any potential interventions provided
- Any care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis
- When referring a child or young person for an assessment in other services (including for psychological interventions), they are supported during the referral period and arrangements for support are agreed beforehand with them[1]

For young people who continue to exhibit antisocial behaviour or meet criteria for a conduct disorder while in transition to adult services (in particular those who are still vulnerable, such as those who have been looked after or who have limited access to care) (see the NICE guideline Antisocial personality disorder. Treatment, management and prevention [NICE clinical guideline 77]). For those who have other mental health problems refer to other NICE guidance for the specific mental health problem.

Selective Prevention

In this guideline selective prevention refers to interventions targeted to individuals or to a subgroup of the population whose risk of developing a conduct disorder is significantly higher than average, as evidenced by individual, family and social risk factors. Individual risk factors include low school achievement and impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education.

Offer classroom-based emotional learning and problem-solving programmes for children aged typically between 3 and 7 years in schools where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder as a result of any of the following factors:

- Low socioeconomic status
- Low school achievement
- Child abuse or parental conflict
- Separated or divorced parents
- Parental mental health or substance misuse problems
- Parental contact with the criminal justice system

Classroom-based emotional learning and problem-solving programmes should be provided in a positive atmosphere and consist of interventions intended to:

- Increase children's awareness of their own and others' emotions
- Teach self-control of arousal and behaviour
- Promote a positive self-concept and good peer relations
- Develop children's problem-solving skills

Typically the programmes should consist of up to 30 classroom-based sessions over the course of 1 school year.

Identification and Assessment

Initial Assessment of Children and Young People With a Possible Conduct Disorder

Adjust delivery of initial assessment methods to:

- The needs of children and young people with a suspected conduct disorder and
- The setting in which they are delivered (e.g., health and social care, educational settings or the criminal justice system)

Undertake an initial assessment for a suspected conduct disorder if a child or young person's parents or carers, health or social care professionals, school or college, or peer group raise concerns about persistent antisocial behaviour.

Do not regard a history of a neurodevelopmental condition (for example, attention deficit hyperactivity disorder [ADHD]) as a barrier to assessment.

For the initial assessment of a child or young person with a suspected conduct disorder, consider using the Strengths and Difficulties Questionnaire (completed by a parent, carer or teacher). Assess for the presence of the following significant complicating factors:

- A coexisting mental health problem (e.g., depression, post-traumatic stress disorder)

- A neurodevelopmental condition (in particular ADHD and autism)
- A learning disability or difficulty
- Substance misuse in young people

If any significant complicating factors are present refer the child or young person to a specialist CAMHS for a comprehensive assessment.

If no significant complicating factors are present consider direct referral for an intervention.

Comprehensive Assessment

A comprehensive assessment of a child or young person with a suspected conduct disorder should be undertaken by a health or social care professional who is competent to undertake the assessment and should:

- Offer the child or young person the opportunity to meet the professional on their own
- Involve a parent, carer or other third party known to the child or young person who can provide information about current and past behaviour
- If necessary involve more than 1 health or social care professional to ensure a comprehensive assessment is undertaken

Before starting a comprehensive assessment, explain to the child or young person how the outcome of the assessment will be communicated to them. Involve a parent, carer or advocate to help explain the outcome.

The standard components of a comprehensive assessment of conduct disorders should include asking about and assessing the following:

- Core conduct disorders symptoms including:
  - Patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years
  - Aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years
- Current functioning at home, at school or college and with peers
- Parenting quality
- History of any past or current mental or physical health problems

Take into account and address possible coexisting conditions such as:

- Learning difficulties or disabilities
- Neurodevelopmental conditions such as ADHD and autism
- Neurological disorders including epilepsy and motor impairments
- Other mental health problems (e.g., depression, post-traumatic stress disorder and bipolar disorder)
- Substance misuse
- Communication disorders (e.g., speech and language problems)

Consider using formal assessment instruments to aid the diagnosis of coexisting conditions, such as:

- The Child Behavior Checklist for all children and young people
- The Strengths and Difficulties Questionnaire for all children or young people
- The Connors Rating Scales – Revised for a child or young person with suspected ADHD
- A validated measure of autistic behaviour for a child or young person with a suspected autism spectrum disorder (see the NGC summary of the NICE guideline Autism. Recognition, referral and diagnosis of children and young people on the autism spectrum, [NICE clinical guideline 128]).
- A validated measure of cognitive ability for a child or young person with a suspected learning disability
- A validated reading test for a child or young person with a suspected reading difficulty.

Assess the risks faced by the child or young person and if needed develop a risk management plan for self-neglect, exploitation by others, self-harm or harm to others.

Assess for the presence or risk of physical, sexual and emotional abuse in line with local protocols for the assessment and management of these problems.

Conduct a comprehensive assessment of the child or young person's parents or carers, which should cover:

- Positive and negative aspects of parenting, in particular any use of coercive discipline

- The parent–child relationship
- Positive and negative adult relationships within the child or young person's family, including domestic violence
- Parental wellbeing, encompassing mental health, substance misuse (including whether alcohol or drugs were used during pregnancy) and criminal behaviour

Develop a care plan with the child or young person and their parents or carers that includes a profile of their needs, risks to self or others, and any further assessments that may be needed. This should encompass the development and maintenance of the conduct disorder and any associated behavioural problems, any coexisting mental or physical health problems and speech, language and communication difficulties, in the context of:

- Any personal, social, occupational, housing or educational needs
- The needs of parents or carers
- The strengths of the child or young person and their parents or carers

Identifying Effective Treatment and Care Options

When discussing treatment or care interventions with a child or young person with a conduct disorder and, if appropriate, their parents or carers, take account of:

- Their past and current experience of the disorder
- Their experience of, and response to, previous interventions and services
- The nature, severity and duration of the problem(s)
- The impact of the disorder on educational performance
- Any chronic physical health problem
- Any social or family factors that may have a role in the development or maintenance of the identified problem(s)
- Any coexisting conditions[2]

When discussing treatment or care interventions with a child or young person and, if appropriate, their parents or carers, provide information about:

- The nature, content and duration of any proposed intervention
- The acceptability and tolerability of any proposed intervention
- The possible impact on interventions for any other behavioural or mental health problem
- The implications for the continuing provision of any current interventions[2]

When making a referral for treatment or care interventions for a conduct disorder, take account of the preferences of the child or young person and, if appropriate, their parents or carers when choosing from a range of evidence-based interventions[2].

Psychosocial Interventions – Treatment and Indicated Prevention

In this guideline indicated prevention refers to interventions targeted to high-risk individuals who are identified as having detectable signs or symptoms that may lead to the development of conduct disorders but who do not meet diagnostic criteria for conduct disorders when offered an intervention.

The interventions in recommendations below are suitable for children and young people who have a diagnosis of oppositional defiant disorder or conduct disorder, are in contact with the criminal justice system for antisocial behaviour, or have been identified as being at high risk of a conduct disorder using established rating scales of antisocial behaviour (e.g., the Child Behavior Checklist and the Eyberg Child Behavior Inventory).

Parent Training Programmes

Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or
- Are in contact with the criminal justice system because of antisocial behaviour

Group parent training programmes should involve both parents if this is possible and in the best interests of the child or young person, and should:

- Typically have between 10 and 12 parents in a group
- Be based on a social learning model, using modelling, rehearsal and feedback to improve parenting skills

- Typically consist of 10 to 16 meetings of 90 to 120 minutes' duration
- Adhere to a developer's manual[3] and employ all of the necessary materials to ensure consistent implementation of the programme

Offer an individual parent training programme to the parents of children and young people aged between 3 and 11 years who are not able to participate in a group parent training programme and whose child:

- Has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Has oppositional defiant disorder or conduct disorder or
- Is in contact with the criminal justice system because of antisocial behaviour

Individual parent training programmes should involve both parents if this is possible and in the best interests of the child or young person, and should:

- Be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- Typically consist of 8 to 10 meetings of 60 to 90 minutes' duration
- Adhere to a developer's manual[3] and employ all of the necessary materials to ensure consistent implementation of the programme

Parent and Child Training Programmes for Children With Complex Needs

Offer individual parent and child training programmes to children and young people aged between 3 and 11 years if their problems are severe and complex and they:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or
- Are in contact with the criminal justice system because of antisocial behaviour

Individual parent and child training programmes should involve both parents, foster carers or guardians if this is possible and in the best interests of the child or young person, and should:

- Be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- Consist of up to 10 meetings of 60 minutes' duration
- Adhere to a developer's manual[3] and employ all of the necessary materials to ensure consistent implementation of the programme

Foster Carer/Guardian Training Programmes

Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or
- Are in contact with the criminal justice system because of antisocial behaviour

Group foster carer/guardian training programmes should involve both of the foster carers or guardians if this is possible and in the best interests of the child or young person, and should:

- Modify the intervention to take account of the care setting in which the child is living
- Typically have between 8 and 12 foster carers or guardians in a group
- Be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- Typically consist of between 12 and 16 meetings of 90 to 120 minutes' duration
- Adhere to a developer's manual[3] and employ all of the necessary materials to ensure consistent implementation of the programme

Offer an individual foster carer/guardian training programme to the foster carers or guardians of children and young people aged between 3 and 11 years who are not able to participate in a group programme and whose child:

- Has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Has oppositional defiant disorder or conduct disorder or
- Is in contact with the criminal justice system because of antisocial behaviour

Individual foster carer/guardian training programmes should involve both of the foster carers if this is possible and in the best interests of the child

or young person, and should:

- Modify the intervention to take account of the care setting in which the child is living
- Be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- Consist of up to 10 meetings of 60 minutes' duration
- Adhere to a developer's manual[3] and employ all of the necessary materials to ensure consistent implementation of the programme

Child-focused Programmes

Offer group social and cognitive problem-solving programmes to children and young people aged between 9 and 14 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or are in contact with the criminal justice system because of antisocial behaviour

Group social and cognitive problem-solving programmes should be adapted to the children's or young people's developmental level and should:

- Be based on a cognitive–behavioural problem-solving model
- Use modelling, rehearsal and feedback to improve skills
- Typically consist of 10 to 18 weekly meetings of 2 hours' duration
- Adhere to a developer's manual[5] and employ all of the necessary materials to ensure consistent implementation of the programme

Multimodal Interventions

Offer multimodal interventions, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder.

Multimodal interventions should involve the child or young person and their parents and carers and should:

- Have an explicit and supportive family focus
- Be based on a social learning model with interventions provided at individual, family, school, criminal justice and community levels
- Be provided by specially trained case managers
- Typically consist of 3 to 4 meetings per week over a 3- to 5-month period
- Adhere to a developer's manual[5] and employ all of the necessary materials to ensure consistent implementation of the programme

Pharmacological Interventions

Do not offer pharmacological interventions for the routine management of behavioural problems in children and young people with oppositional defiant disorder or conduct disorder.

Offer methylphenidate or atomoxetine, within their licensed indications, for the management of ADHD in children and young people with oppositional defiant disorder or conduct disorder (see the NGC summary of the NICE guideline Attention deficit hyperactivity disorder: diagnosis and management [NICE clinical guideline 72]).

Consider risperidone[4] for the short-term management of severely aggressive behaviour in young people with a conduct disorder who have problems with explosive anger and severe emotional dysregulation and who have not responded to psychosocial interventions.

Provide young people and their parents or carers with age-appropriate information and discuss the likely benefits and possible side effects of risperidone[4] including:

- Metabolic (including weight gain and diabetes)
- Extrapyramidal (including akathisia, dyskinesia and dystonia)
- Cardiovascular (including prolonging the QT interval)
- Hormonal (including increasing plasma prolactin)
- Other (including unpleasant subjective experiences)

Risperidone[4] should be started by an appropriately qualified healthcare professional with expertise in conduct disorders and should be based on a comprehensive assessment and diagnosis. The healthcare professional should undertake and record the following baseline investigations:

- Weight and height (both plotted on a growth chart)

- Waist and hip measurements
- Pulse and blood pressure
- Fasting blood glucose, glycosylated haemoglobin (HbA_{1c}), blood lipid and prolactin levels
- Assessment of any movement disorders
- Assessment of nutritional status, diet and level of physical activity

Treatment with risperidone[4] should be carefully evaluated, and include the following:

- Record the indications and expected benefits and risks, and the expected time for a change in symptoms and appearance of side effects.
- At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British National Formulary for Children (BNFC) or the summary of product characteristics (SPC).
- Justify and record reasons for dosages above the range given in the BNFC or SPC.
- Monitor and record systematically throughout treatment, but especially during titration:
    - Efficacy, including changes in symptoms and behaviour
    - The emergence of movement disorders
    - Weight and height (weekly)
    - Fasting blood glucose, HbA_{1c}, blood lipid and prolactin levels
    - Adherence to medication
    - Physical health, including warning parents or carers and the young person about symptoms and signs of neuroleptic malignant syndrome
- Record the rationale for continuing or stopping treatment and the effects of these decisions[4].

Review the effects of risperidone[4] after 3 to 4 weeks and discontinue it if there is no indication of a clinically important response at 6 weeks.

Organisation and Delivery of Care

Improving Access to Services

Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways that promote access to services for children and young people with a conduct disorder and their parents and carers by:

- Supporting the integrated delivery of services across all care settings
- Having clear and explicit criteria for entry to the service
- Focusing on entry and not exclusion criteria
- Having multiple means (including self-referral) of access to the service
- Providing multiple points of access that facilitate links with the wider care system, including educational and social care services and the community in which the service is located[2]

Provide information about the services and interventions that constitute the local care pathway, including the:

- Range and nature of the interventions provided
- Settings in which services are delivered
- Processes by which a child or young person moves through the pathway
- Means by which progress and outcomes are assessed
- Delivery of care in related health and social care services[5]

When providing information about local care pathways for children and young people with a conduct disorder and their parents and carers:

- Take into account the person's knowledge and understanding of conduct disorders and their care and treatment.
- Ensure that such information is appropriate to the communities using the pathway[2].

Provide all information about services in a range of languages and formats (visual, verbal and aural) and ensure that it is available in a range of settings throughout the whole community to which the service is responsible[5].

Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to develop local care pathways that promote access for a range of groups at risk of under-utilising services, including:

- Girls and young women
- Black and minority ethnic groups
- People with a coexisting condition (such as ADHD or autism)[2]

Support access to services and increase the uptake of interventions by:

- Ensuring systems are in place to provide for the overall coordination and continuity of care
- Designating a professional to oversee the whole period of care (for example, a staff member in a CAMHS or social care setting)[2]

Support access to services and increase the uptake of interventions by providing services for children and young people with a conduct disorder and their parents and carers, in a variety of settings. Use an assessment of local needs as a basis for the structure and distribution of services, which should typically include delivery of:

- Assessment and interventions outside normal working hours
- Assessment and interventions in the person's home or other residential settings
- Specialist assessment and interventions in accessible community-based settings (for example, community centres, schools and colleges and social centres) and if appropriate, in conjunction with staff from those settings
- Both generalist and specialist assessment and intervention services in primary care settings[2]

Health and social care professionals, managers and commissioners should collaborate with colleagues in educational settings to look at a range of services to support access to and uptake of services. These could include:

- Crèche facilities
- Assistance with travel
- Advocacy services[2]

Developing Local Care Pathways

Local care pathways should be developed to promote implementation of key principles of good care. Pathways should be:

- Negotiable, workable and understandable for children and young people with a conduct disorder and their parents and carers as well as professionals
- Accessible and acceptable to all people in need of the services served by the pathway
- Responsive to the needs of children and young people with a conduct disorder and their parents and carers
- Integrated so that there are no barriers to movement between different levels of the pathway
- Focused on outcomes (including measures of quality, service user experience and harm)[2]

Responsibility for the development, management and evaluation of local care pathways should lie with a designated leadership team, which should include health and social care professionals, managers and commissioners. The leadership team should work in collaboration with colleagues in educational settings and take particular responsibility for:

- Developing clear policy and protocols for the operation of the pathway
- Providing training and support on the operation of the pathway
- Auditing and reviewing the performance of the pathway[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote a model of service delivery that:

- Has clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- Does not use single criteria such as symptom severity or functional impairment to determine movement within the pathway
- Monitors progress and outcomes to ensure the most effective interventions are delivered[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote a range of evidence-based interventions in the pathway and support children and young people with a conduct disorder and their parents and carers in their choice of interventions[2].

- All staff should ensure effective engagement with parents and carers, if appropriate, to:
    - Inform and improve the care of the child or young person with a conduct disorder

- Meet the needs of parents and carers[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that promote the active engagement of all populations served by the pathway. Pathways should:

- Offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of children and young people with a conduct disorder and their parents and carers
- Keep to a minimum the number of assessments needed to access interventions[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that respond promptly and effectively to the changing needs of all populations served by the pathways. Pathways should have in place:

- Clear and agreed goals for the services offered to children and young people with a conduct disorder and their parents and carers
- Robust and effective means for measuring and evaluating the outcomes associated with the agreed goals
- Clear and agreed mechanisms for responding promptly to changes in individual needs[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that provide an integrated programme of care across all care settings. Pathways should:

- Minimise the need for transition between different services or providers
- Allow services to be built around the pathway and not the pathway around the services
- Establish clear links (including access and entry points) to other care pathways (including those for physical healthcare needs)
- Have designated staff who are responsible for the coordination of people's engagement with the pathway[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to ensure effective communication about the functioning of the local care pathway. There should be protocols for:

- Sharing information with children and young people with a conduct disorder, and their parents and carers, about their care
- Sharing and communicating information about the care of children and young people with other professionals (including general practitioners)
- Communicating information between the services provided within the pathway
- Communicating information to services outside the pathway[2]

Health and social care professionals, managers and commissioners should work with colleagues in educational settings to design local care pathways that have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. This should include providing:

- Individual routine outcome measurement systems
- Effective electronic systems for the routine reporting and aggregation of outcome measures
- Effective systems for the audit and review of the overall clinical and cost effectiveness of the pathway[2]

[1] Adapted from Service user experience in adult mental health (NICE clinical guidance 136).

[2] Adapted from Common mental health disorders (NICE clinical guideline 123).

[3] The manual should have been positively evaluated in a randomised controlled trial.

[4] At the time of publication (March 2013) some preparations of risperidone did not have a UK marketing authorisation for this indication in young people and no preparations were authorised for use in children aged under 5 years. The prescriber should consult the summary of product characteristics for the individual risperidone and follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[5] From Common mental health disorders (NICE clinical guideline 123).

Clinical Algorithm(s)

A NICE pathway for children and young people with antisocial behaviour and conduct disorders is available from the National Institute for Health and Clinical Excellence (NICE) Web site.

Scope

Disease/Condition(s)

Conduct disorders and associated antisocial behaviour, including:

- Oppositional defiant disorder
- Persistent offending behaviour

Guideline Category

Counseling

Management

Prevention

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To evaluate the clinical effectiveness and safety of indicated prevention and treatment interventions for conduct disorders
- To evaluate if any modifications should be made to interventions to take into account coexisting conditions or demographic variation
- To conduct a systematic review of the effectiveness of interventions which aim to prevent "at risk" children and young people from developing a conduct disorder
- To identify and evaluate the most effective instruments for case identification of conduct disorders in children and young people
- Access to and delivery of services:
    - To identify barriers relating to the individual child/parents/family carers, the practitioner, the healthcare/social care and other service systems that prevent an individual from accessing services
    - To evaluate any methods and models designed to improve access for children and young people, and/or their parents/ family/carers requiring services
- Experience of care:
    - To identify the experiences of having the disorder, access to services, and treatment on children and young people
    - To identify the experiences of support that parents and carers of children and young people with conduct disorders receive

Target Population

- Children and young people (aged 18 years and younger) with a diagnosed or suspected conduct disorder, including looked-after children and those in contact with the criminal justice system
- Parents/families/carers of children and young people who are considered to be "at risk" of developing a conduct disorder

Interventions and Practices Considered

Assessment/Diagnosis

1. Identification and assessment of children and young people with a possible conduct disorder
    - Comprehensive assessment
    - Assessment for coexisting mental health problem, neuro-developmental condition, learning disability/difficulty and substance misuse
    - Strengths and difficulties questionnaire (completed by a parent, carer or teacher)
    - Assessment for presence or risk of physical, sexual and emotional abuse
    - Comprehensive assessment of the child or young person's parents or carers

Management/Treatment

1. Establishment of relationships with children, young people and their parents or carers
2. Communication and provision of information
3. Practices to address culture, ethnicity and social inclusion
4. Staff supervision and monitoring
5. Transfer and discharge from services
6. Interventions for selective prevention
7. Development of a risk management plan
8. Development of a care plan
9. Psychosocial interventions
    - Parent training programmes
    - Parent and child training programmes for children with complex needs
    - Foster carer/guardian training programmes
    - Child-focused programmes
    - Multimodal interventions
10. Pharmacological interventions
    - Methylphenidate
    - Atomoxetine
    - Risperidone
11. Organisation and delivery of care
    - Improving access to services
    - Developing local care pathways

Major Outcomes Considered

- Child outcomes:
  - Agency contact (for example residential care, criminal justice system)
  - Antisocial behaviour (at home, at school, in the community)
  - Drug/alcohol use
  - Educational attainment (that is, the highest level of education completed)
  - Offending behaviour
  - School exclusion due to antisocial behaviour
- Cost-effectiveness of treatment

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned the National Collaborating Centre for Mental Health (NCCMH) in partnership with the Social Care Institute for Excellence to develop this guideline (see the "Availability of Companion Documents" field).

A stepwise, hierarchical approach was taken to locating and presenting evidence to the guideline development group (GDG). The NCCMH developed this process based on methods set out in The Guidelines Manual (see the "Availability of Companion Documents" field), and after considering recommendations from a range of other sources. These included:

- British Medical Journal (BMJ) Clinical Evidence
- Clinical Policy and Practice Program of the New South Wales Department of Health (Australia)
- The Cochrane Collaboration
- Grading of Recommendations Assessment, Development and Evaluation (GRADE) Working Group
- New Zealand Guidelines Group
- National Health Service (NHS) Centre for Reviews and Dissemination
- Oxford Centre for Evidence-Based Medicine
- Oxford Systematic Review Development Programme
- Scottish Intercollegiate Guidelines Network
- United States (US) Agency for Healthcare Research and Quality

The Review Process

Scoping Searches

A broad preliminary search of the literature was undertaken in November 2010 to obtain an overview of the issues likely to be covered by the scope, and to help define key areas.

Searches were restricted to clinical guidelines, health technology assessment reports and key systematic reviews, and conducted in the following databases and websites:

- BMJ Clinical Evidence
- Canadian Medical Association Infobase (Canadian guidelines)

- Clinical Policy and Practice Program of the New South Wales Department of Health (Australia)
- Clinical Practice Guidelines (Australian guidelines)
- Cochrane Central Register of Controlled Trials
- Cochrane Database of Abstracts of Reviews of Effects
- Cochrane Database of Systematic Reviews
- Excerpta Medica Database (Embase)
- Guidelines International Network
- Health Evidence Bulletin Wales
- Health Management Information Consortium
- Health Technology Assessment (HTA) database (technology assessments)
- Medical Literature Analysis and Retrieval System Online MEDLINE/MEDLINE in Process
- National Health and Medical Research Council
- New Zealand Guidelines Group
- NHS Centre for Reviews and Dissemination
- Organizing Medical Networked Information Medical Search
- Scottish Intercollegiate Guidelines Network
- Turning Research Into Practice
- US Agency for Healthcare Research and Quality
- Websites of NICE – including NHS Evidence – and the National Institute for Health Research HTA Programme for guidelines and HTAs in development

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate as much relevant evidence as possible. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to systematic reviews, randomised controlled trials (RCTs) and observational studies, and conducted in the following databases:

- Australian Education Index
- Applied Social Services Index and Abstracts
- British Education Index
- Campbell Collaboration
- Cumulative Index to Nursing and Allied Health Literature
- Cochrane Database of Systematic Reviews
- Central (centralised database of RCTs and other controlled studies)
- Database of Abstracts and Reviews of Effectiveness
- Embase
- Education Resources in Curriculum
- Health Management Information Consortium
- HTA database (technology assessments)
- International Bibliography of Social Sciences
- Medical Literature Analysis and Retrieval System Online (MEDLINE/in-process database for MEDLINE [PreMEDLINE])
- National Criminal Justice Reference Service
- PsycBOOKS, the full-text database of books and chapters in the American Psychological Association's electronic databases
- PsycEXTRA, a grey literature database, which is a companion to PsycINFO
- Psychological Information Database (PsycINFO)
- Social Science Abstracts
- Social Science Citation Index
- Sociological Abstracts
- Web-based searches for additional evidence were performed in Social Care Online

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches, and discussion of the results of the searches with the review team and GDG, to ensure that all possible relevant search terms were covered. In order to assure comprehensive coverage, search terms for the main population were kept purposely broad to help

counter dissimilarities in database indexing practices, and imprecise reporting of study populations by authors in the titles and abstracts of records. For standard mainstream bibliographic databases (Embase, MEDLINE, PreMEDLINE and PsycINFO), search terms for main population were combined with the intervention(s), together with a research-based filter for the study design of interest. For smaller, topic-specific databases (for example education and sociological databases), a search, modified to be more precise, was conducted for the main population and study design of interest only. The search terms for each search are set out in full in Appendix 7 in the full version of the original guideline document.

EndNote

Citations from each search were downloaded into the reference management software and duplicates removed. Records were then screened against the eligibility criteria of the reviews before being quality appraised (see the "Study Selection and Quality Assessment" section, below). The unfiltered search results were saved and retained for future potential re-analysis, to help keep the process both replicable and transparent.

Search Filters

To aid retrieval of relevant and sound studies, filters were used to limit a number of searches to systematic reviews, RCTs and observational studies. The search filters for systematic reviews and RCTs are adaptations of filters designed by the Centre for Reviews Dissemination, York, the Health Information Research Unit of McMaster University, Ontario, and the University of Alberta. The observational study filter is an in-house development. Each filter comprises index terms relating to the study type(s) and associated textwords for the methodological description of the design(s).

Date and Language Restrictions

Systematic database searches were initially conducted in June 2011 up to the most recent searchable date. Search updates were generated on a 6-monthly basis, with the final re-runs carried out in July 2012 ahead of the guideline consultation. After this point, studies were only included if they were judged by the GDG to be exceptional (for example if the evidence was likely to change a recommendation).

Although no language restrictions were applied at the searching stage, foreign language papers were not requested or reviewed, unless they were of particular importance to a review question.

Date restrictions were not applied, except for searches of systematic reviews which were limited to research published from 1995. This restriction was put in place because older reviews were thought to be less useful.

Other Search Methods

Other search methods involved: (a) scanning the reference lists of all eligible publications (systematic reviews, stakeholder evidence and included studies) for more published reports and citations of unpublished research; (b) sending lists of studies meeting the inclusion criteria to subject experts (identified through searches and the GDG) and asking them to check the lists for completeness, and to provide information of any published or unpublished research for consideration (Appendix 4 in the full version of the original guideline document); (c) checking the tables of contents of key journals for studies that might have been missed by the database and reference list searches; (d) tracking key papers in the Science Citation Index (prospectively) over time for further useful references; (e) conducting searches in ClinicalTrials.gov for unpublished trial reports; (f) contacting included study authors for unpublished or incomplete data sets. Searches conducted for existing NICE guidelines were updated where necessary. Other relevant guidelines were assessed for quality using the Appraisal of Guidelines for Research and Evaluation Instrument (AGREE) instrument (AGREE Collaboration, 2003). The evidence base underlying high-quality existing guidelines was utilised and updated as appropriate.

Full details of the search strategies and filters used for the systematic review of clinical evidence are provided in Appendix 7 in the full version of the original guideline document.

Study Selection and Quality Assessment

All primary-level studies included after the first scan of citations were acquired in full and re-evaluated for eligibility at the time they were being entered into the study information database. More specific eligibility criteria were developed for each review question and are described in the relevant clinical evidence chapters. Eligible systematic reviews and primary-level studies were critically appraised for methodological quality (see Appendix 9 in the full version of the original guideline document for further information). The eligibility of each study was confirmed by at least one member of the appropriate topic group.

For some review questions, it was necessary to prioritise the evidence with respect to the UK context (that is, external validity). To make this process explicit, the topic groups took into account the following factors when assessing the evidence:

- Participant factors (for example gender, age and ethnicity)
- Provider factors (for example model fidelity, the conditions under which the intervention was performed and the availability of experienced

staff to undertake the procedure)
- Cultural factors (for example differences in standard care and differences in the welfare system)

It was the responsibility of each topic group to decide which prioritisation factors were relevant to each review question in light of the UK context and then decide how they should modify their recommendations.

Unpublished Evidence

The GDG used a number of criteria when deciding whether or not to accept unpublished data. First, the evidence must have been accompanied by a trial report containing sufficient detail to properly assess the quality of the data. Second, the evidence must have been submitted with the understanding that data from the study and a summary of the study's characteristics would be published in the full guideline. Therefore, the GDG did not accept evidence submitted as commercial in confidence. However, the GDG recognised that unpublished evidence submitted by investigators might later be retracted by those investigators if the inclusion of such data would jeopardise publication of their research.

Search Strategy for Economic Evidence

Scoping Searches

A broad preliminary search of the literature was undertaken in November 2010 to obtain an overview of the issues likely to be covered by the scope, and help define key areas. Searches were restricted to economic studies and health technology assessment reports, and conducted in the following databases:

- Embase
- MEDLINE / MEDLINE In-Process
- HTA database (technology assessments)
- NHS Economic Evaluation Database

Any relevant economic evidence arising from the clinical scoping searches was also made available to the health economist during the same period.

Systematic Literature Searches

After the scope was finalised, a systematic search strategy was developed to locate all the relevant evidence. The balance between sensitivity (the power to identify all studies on a particular topic) and specificity (the ability to exclude irrelevant studies from the results) was carefully considered, and a decision made to utilise a broad approach to searching to maximise retrieval of evidence to all parts of the guideline. Searches were restricted to economic studies and health technology assessment reports, and conducted in the following databases:

- EconLit (the American Economic Association's electronic bibliography)
- Embase
- HTA database (technology assessments)
- MEDLINE / MEDLINE In-Process
- NHS Economic Evaluation Database
- PsycINFO

Any relevant economic evidence arising from the clinical searches was also made available to the health economist during the same period.

The search strategies were initially developed for MEDLINE before being translated for use in other databases/interfaces. Strategies were built up through a number of trial searches, and discussions of the results of the searches with the review team and GDG to ensure that all possible relevant search terms were covered. In order to ensure comprehensive coverage, search terms for the main population were kept purposely broad to help counter dissimilarities in database indexing practices, and imprecise reporting of study populations by authors in the titles and abstracts of records. For standard mainstream bibliographic databases (Embase, MEDLINE, PreMEDLINE and PsycINFO), search terms for the main population were combined with the intervention(s), together with a study design filter for health economic research. For smaller, topic-specific databases (for example EconLit, HTA, NHS Economic Evaluation Database), a broad search was conducted for the main population, only. The search terms are set out in full in Appendix 10 of the original guideline document.

Further details of the search strategies and filter used for the systematic review of health economic evidence are provided in Section 3.6.1 and Appendix 10 of the full version of the original guideline. Inclusion criteria are provided in Section 3.6.2 of the full version of the guideline. For results of the systematic search of economic literature refer to Section 3.6.5.

Number of Source Documents

Of the 58 eligible trials, 31 (N = 9,393) included sufficient data to be included in the meta-analysis (selective prevention intervention compared with a control group), and categorised as child-focused (delivered to child only), parent-focused (delivered to parent only), parent-child-based (separate interventions delivered to parent and child), parent-teacher-based (separate interventions delivered to parent and teacher), family-focused (delivered to the family), multi-component (separate interventions delivered to parents, child, and family or school classroom-based – teacher involved (programmes delivered in classrooms and involving a teacher), and classroom-based – other, non-teacher, involved (programmes delivered in classrooms, but involving someone other than a teacher).

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Overall Quality of Outcome Evidence in Grading of Recommendations Assessment, Development, and Evaluation (GRADE)

High: Further research is very unlikely to change the Guideline Development Group's (GDG) confidence in the estimate of effect.

Moderate: Further research is likely to have an important impact on the GDG's confidence in the estimate of effect and may change the estimate.

Low: Further research is very likely to have an important impact on the GDG's confidence in the estimate of effect and is likely to change the estimate.

Very Low: The GDG is very uncertain about the estimate.

Methods Used to Analyze the Evidence

Meta-Analysis of Randomized Controlled Trials

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned the National Collaborating Centre for Mental Health (NCCMH) in partnership with the Social Care Institute for Excellence to develop this guideline (see the "Availability of Companion Documents" field).

Data Extraction

Study characteristics and outcome data were extracted from all eligible studies that met the minimum quality criteria, using Review Manager 5.1 and an Excel-based form (see Appendix 8 in the full version of the original guideline document).

In most circumstances, for a given outcome (continuous and dichotomous), where more than 50% of the number randomised to any group were missing or incomplete, the study results were excluded from the analysis (except for the outcome "leaving the study early", in which case the denominator was the number randomised). Where there was limited data for a particular review the 50% rule was not applied. In these circumstances the evidence was downgraded due to the risk of bias.

Where possible, we used outcome data from an intention-to-treat (ITT) analysis (that is, a "once-randomised-always-analyse" basis). For dichotomous efficacy outcomes we re-calculated the effect size if ITT had not been used. When making the calculations, if there was good evidence that those participants who ceased to engage in the study were likely to have an unfavourable outcome, early withdrawals were included in both the numerator and denominator. Adverse effects were entered into Review Manager as reported by the study authors because it is usually not possible to determine whether early withdrawals had an unfavourable outcome.

Consultation with another reviewer or members of the guideline development group (GDG) was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by one reviewer and cross-checked with the existing data set.

Double data extraction of new data was only undertaken for studies reporting very large effect sizes. Masked assessment (that is, blind to the journal from which the article comes, the authors, the institution and the magnitude of the effect) was not used since it is unclear that doing so reduces bias.

Synthesising the Evidence from Comparative Effectiveness Studies

Outcome Measures

Many studies include a wide range of outcome measures from different sources (researchers, parents, teachers, clinicians and self) to explore the clinical and social benefits of interventions for conduct disorders. In addition to being of research interest, this wider approach to outcomes mirrors the breadth of contexts within which conduct disordered behaviour is presented, although this heterogeneity brings challenges in determining the relative reliability of measures made by different categories of informant.

For the purposes of the meta-analyses, the GDG established a list of outcomes that it rated as critical and focused on these when making recommendations. For children and young people this included the following outcome categories: agency contact (for example residential care, criminal justice system); antisocial behaviour (at home, at school, in the community); drug/alcohol use, educational attainment (that is, the highest level of education completed); offending behaviour; and, school exclusion due to antisocial behaviour.

For each outcome category, where available, data were extracted for parent-, teacher-, researcher/clinician-, and observer-reported outcomes. Only outcome measures that were judged to be established and valid were used in the analysis; less recognised measures, for instance those developed for a particular study were therefore not used.

Meta-Analysis

Where possible, meta-analysis was used to synthesise evidence from comparative effectiveness studies using Comprehensive Meta-Analysis software, Version 2.2.048 and Stata, Version 9.2. If necessary, re-analyses of the data or sub-analyses were used to answer review questions not addressed in the original studies or reviews.

Dichotomous outcomes were analysed as relative risks (RR) with the associated 95% confidence interval (CI) (see Figure 1 in the full version of the original guideline document for an example of a forest plot displaying dichotomous data). A relative risk (also called a risk ratio) is the ratio of the treatment event rate to the control event rate. An RR of 1 indicates no difference between treatment and control. In Figure 1 (in the full version of the original guideline document), the overall RR of 0.73 indicates that the event rate (that is, non-remission rate) associated with intervention A is about three-quarters of that with the control intervention or, in other words, the relative risk reduction is 27%.

The CI shows a range of values within which we are 95% confident that the true effect will lie. If the effect size has a CI that does not cross the "line of no effect", then the effect is commonly interpreted as being statistically significant.

Continuous outcomes were analysed using the standardised mean difference (SMD) when different measures were used in different studies to estimate the same underlying effect (see Figure 2 in the full version of the original guideline document for an example of a forest plot displaying continuous data). If reported by study authors, ITT data, using a valid method for imputation of missing data, were preferred over data only from people who completed the study.

Because the outcomes of interest have often been measured using different scales within a single study, and the GDG were interested in the effect of an intervention when rated by different people (for example observer and parent), the following procedures were employed. First, relevant data were categorised by rater (that is, observer, researcher/clinician, teacher, parent, self). Second, within each rater category, data from multiple outcomes were pooled using comprehensive meta-analysis (one effect size per study for post-treatment results, and where available, another effect size for the longest follow-up). These data were transferred to Stata, which was used to synthesise results across studies.

Heterogeneity

To check for consistency of effects among studies, both the I^2 statistic and the chi-squared test of heterogeneity, as well as a visual inspection of the forest plots were used. The I^2 statistic describes the proportion of total variation in study estimates that is due to heterogeneity. The I^2 statistic was interpreted in the follow way based on the Cochrane Handbook for Systematic Reviews of Interventions:

- 0% to 40%: might not be important
- 30% to 60%: may represent moderate heterogeneity
- 50% to 90%: may represent substantial heterogeneity
- 75% to 100%: considerable heterogeneity

Two factors were used to make a judgement about importance of the observed value of I^2: (1) the magnitude and direction of effects, and (2) the strength of evidence for heterogeneity (for example p value from the chi-squared test, or a confidence interval for I^2).

Where important heterogeneity was detected, random effects univariate meta-regression models were used to examine whether any reported factors explained any of the variance. We then created a multivariate meta-regression model including all factors that were shown in the univariate models to explain at least some of the variance.

To examine how much of the heterogeneity was accounted for by the factor(s) included in each model, we used the adjusted R^2 produced by the revised metareg command in Stata. Sensitivity analyses were also used to explore the effect of removing studies with high risk of bias, and studies of attenuated interventions (that is, those interventions judged by the GDG to be very brief or because they were self-administered versions of an intervention usually administered by a therapist/researcher).

Publication Bias

The GDG assessed the possibility of publication bias using the Stata metabias command. Where there was evidence of significant asymmetry in the funnel plot (as judged by the Begg and Mazumdar adjusted rank correlation test), the Stata metatrim command was used to perform the Duval and Tweedie nonparametric "trim and fill" method. This method was used to examine the impact of the missing studies by adjusting the meta-analysis to take into account the theoretically missing studies. We only report these data were possible publication bias was detected.

Synthesising the Evidence from Test Accuracy Studies

Meta-Analysis

Review Manager 5 was used to summarise test accuracy data from each study using forest plots and summary receiver operator characteristic (ROC) plots. Where more than two studies reported appropriate data, a bivariate test accuracy meta-analysis was conducted using Meta-DiSc in order to obtain pooled estimates of sensitivity, specificity, and positive and negative likelihood ratios.

Sensitivity and Specificity

The sensitivity of an instrument refers to probability that it will produce a true positive result when given to a population with the target disorder (as compared with a reference or "gold standard"). An instrument that detects a low percentage of cases will not be very helpful in determining the numbers of service users who should receive further assessment or a known effective treatment, because many individuals who should receive the treatment will not do so. This would lead to an under-estimation of the prevalence of the disorder, contribute to inadequate care and make for poor planning and costing of the need for treatment. As the sensitivity of an instrument increases, the number of false negatives it detects will decrease.

The specificity of an instrument refers to the probability that a test will produce a true negative result when given to a population without the target disorder (as determined by a reference or "gold standard"). This is important so that healthy people are not offered further assessment or treatments they do not need. As the specificity of an instrument increases, the number of false positives will decrease.

When describing the sensitivity and specificity of the different instruments, the GDG defined values above 0.9 as "excellent", 0.8 to 0.9 as "good", 0.5 to 0.7 as "moderate", 0.3 to 0.4 as "low", and less than 0.3 as "poor".

Receiver Operator Characteristic (ROC) Curves

The qualities of a particular tool are summarised in a ROC curve, which plots sensitivity (expressed as a per cent) against (100-specificity) (see Figure 3 in the full version of the original guideline document).

A test with perfect discrimination would have an ROC curve that passed through the top left hand corner; that is, it would have 100% specificity and pick up all true positives with no false positives. While this is never achieved in practice, the area under the curve (AUC) measures how close the tool gets to the theoretical ideal. A perfect test would have an AUC of 1, and a test with AUC above 0.5 is better than chance. As discussed above, because these measures are based on sensitivity and 100-specificity, theoretically these estimates are not affected by prevalence.

Negative and Positive Likelihood Ratios

Negative and positive likelihood ratios are thought not to be dependent on prevalence. The positive likelihood ratio is calculated by sensitivity/(1-specificity) and negative likelihood ratio is (1-sensitivity)/specificity. A positive likelihood ratio with a value of >5 and a negative likelihood ratio of <0.3 suggests the test is relatively accurate.

Synthesising the Evidence from Studies About the Experience of Care

Themes from evidence about the experience of care were collated using the matrix of service user experience developed for the service user guidance and quality standard. The matrix was formed by creating a table with the eight dimensions of patient-centred care developed by the Picker Institute Europe (see Appendix 13 in the full version of the original guideline document for more information), down the vertical axis, and the key points on a pathway of care (as specified by the GDG) across the horizontal axis (see Table 5 in the full version of the original guideline document). With regard to terminology, the service user experience guidance used the term "person-centred" rather than "patient-centred", therefore the former is used in the matrix.

The Picker Institute's dimensions of patient-centred care were chosen because they are well established, comprehensive, and based on research. In addition, a variation of these dimensions has been adopted by the US Institute of Medicine.

Themes evident within the matrix were used during a consultation undertaken with a focus group (User Voice, see Section 4.2.5., in the full version of the original guideline document; see Appendix 14 in the full version of the original guideline document for a description of the methods used). In addition, the evidence obtained from the reviews was used to inform the process of incorporation and adaptation of existing guideline recommendations where there was insufficient evidence to support the development of recommendations in areas the GDG considered to be important (see Sections 4.3. and 3.7., in the full version of the original guideline document, for a description of the methods used).

Health Economic Methods

The aim of the health economics was to contribute to the guideline's development by providing evidence on the cost effectiveness of interventions for conduct disorders in children and young people covered in the guideline. This was achieved by:

- Systematic literature review of existing economic evidence
- Economic modelling, where economic evidence was lacking or was considered inadequate to inform decisions

Systematic reviews of economic literature were conducted in all areas covered in the guideline. Economic modelling was undertaken in areas with likely major resource implications, where the current extent of uncertainty over cost effectiveness was significant and economic analysis was expected to reduce this uncertainty, in accordance with The Guidelines Manual (NICE, 2009b; see the "Availability of Companion Documents" field). Prioritisation of areas for economic modelling was a joint decision between the Health Economist and the GDG. The rationale for prioritising review questions for economic modelling was set out in an economic plan agreed between NICE, the GDG, the Health Economist and the other members of the technical team. The following economic questions were selected as key issues that were addressed by economic modelling:

1. What is the cost-effectiveness of child-focused interventions for children and young people with conduct disorder?
2. What is the cost-effectiveness of parent-focused interventions for children and young people with conduct disorder?
3. What is the cost-effectiveness of multi-modal interventions for children and young people with conduct disorder?

In addition, literature on the health-related quality of life of children and young people with a conduct disorder was systematically searched to identify studies reporting appropriate utility scores that could be utilised in a cost-utility analysis.

Methods employed in economic modelling are described in the respective sections of the guideline.

Methods Used to Formulate the Recommendations

Expert Consensus

Informal Consensus

Description of Methods Used to Formulate the Recommendations

The Guideline Development Group (GDG)

During the consultation phase, members of the GDG were appointed by an open recruitment process. GDG membership consisted of: professionals in psychiatry, clinical psychology, nursing, social care, and general practice; academic experts in psychiatry and psychology; and carers of children and young people with a conduct disorder. The guideline development process was supported by staff from the National Collaborating Centre for Mental Health (NCCMH), who undertook the clinical and health economics literature searches, reviewed and presented the evidence to the GDG, managed the process, and contributed to drafting the guideline.

Guideline Development Group Meetings

Twelve GDG meetings were held between 13 April 2011 and 31 October 2012. During each day-long GDG meeting, in a plenary session, review questions and clinical and economic evidence were reviewed and assessed, and recommendations formulated. At each meeting, all GDG members declared any potential conflicts of interest, and service user and carer concerns were routinely discussed as a standing agenda item.

Topic Groups

The GDG divided its workload along clinically relevant lines to simplify the guideline development process, and GDG members formed smaller topic groups to undertake guideline work in that area of clinical practice. Topic Group 1 covered questions relating to prevention. Topic Group 2 covered interventions and Topic Group 3 covered health economics. These groups were designed to efficiently manage the large volume of evidence appraisal prior to presenting it to the GDG as a whole. Each topic group was chaired by a GDG member with expert knowledge of the topic area (one of the healthcare professionals). Topic groups refined the review questions and the clinical definitions of treatment interventions, reviewed and prepared the evidence with the systematic reviewer before presenting it to the GDG as a whole, and helped the GDG to identify further expertise in the topic. Topic group leaders reported the status of the group's work as part of the standing agenda. They also introduced and led the GDG discussion of the evidence review for that topic and assisted the GDG Chair in drafting the section of the guideline relevant to the work of each topic group.

Service Users and Carers

Individuals with direct experience of services gave an integral service-user focus to the GDG and the guideline. The GDG included two carers, who contributed as full GDG members to writing the review questions, helping to ensure that the evidence addressed their views and preferences, highlighting sensitive issues and terminology relevant to the guideline, and bringing service-user research to the attention of the GDG. In drafting the guideline, they contributed to writing the guideline's introduction and identified recommendations from the service user and carer perspective.

National and International Experts

National and international experts in the area under review were identified through the literature search and through the experience of the GDG members. These experts were contacted to identify unpublished or soon-to-be published studies, to ensure that up-to-date evidence was included in the development of the guideline. They informed the group about completed trials at the pre-publication stage, systematic reviews in the process of being published, studies relating to the cost effectiveness of treatment and trial data if the GDG could be provided with full access to the complete trial report. Appendix 4 in the full version of the original guideline document lists researchers who were contacted.

Review Questions

Review (clinical) questions were used to guide the identification and interrogation of the evidence base relevant to the topic of the guideline. Before the first GDG meeting, draft review questions were prepared by NCCMH staff based on the scope and an overview of existing guidelines, and discussed with the GDG Chair. The draft review questions were then discussed by the GDG at the first few meetings and amended as necessary. Where appropriate, the questions were refined once the evidence had been searched and, where necessary, sub-questions were generated. Questions submitted by stakeholders were also discussed by the GDG and the rationale for not including any questions was recorded in the minutes. The final list of review questions can be found in Appendix 5 in the full version of the original guideline document.

For questions about interventions, the PICO (population, intervention, comparison and outcome) framework was used (see Table 3 in the full version of the original guideline document).

Questions relating to case identification do not involve an intervention designed to treat a particular condition; therefore, the PICO framework was not used. Rather, the questions were designed to pick up key issues specifically relevant to clinical utility, for example their accuracy, reliability, safety and acceptability to the service user.

In some situations, the prognosis of a particular condition is of fundamental importance, over and above its general significance in relation to specific interventions. Areas where this is particularly likely to occur relate to assessment of risk, for example in terms of behaviour modification or screening and early intervention. In addition, review questions related to issues of service delivery are occasionally specified in the remit from the Department of Health/Welsh Assembly Government. In these cases, appropriate review questions were developed to be clear and concise.

To help facilitate the literature review, a note was made of the best study design type to answer each question. There are four main types of review question of relevance to NICE guidelines. These are listed in Table 4 in the full version of the original guideline document. For each type of question, the best primary study design varies, where "best" is interpreted as "least likely to give misleading answers to the question".

However, in all cases, a well-conducted systematic review (of the appropriate type of study) is likely to always yield a better answer than a single study.

Deciding on the best design type to answer a specific review question does not mean that studies of different design types addressing the same question were discarded.

Extrapolation

When answering review questions, it may be necessary to consider extrapolating from another data set where direct evidence from a primary data set is not available. In this situation, the following principles were used to determine when to extrapolate:

- A primary dataset is absent, of low quality or is judged to be not relevant to the review question under consideration
- A review question is deemed by the GDG to be important, such that in the absence of direct evidence other data sources should be considered
- A non-primary data source(s) is in the view of the GDG available which may inform the review question

When the decision to extrapolate was made, the following principles were used to inform the choice of the non-primary data set:

- The populations (usually in relation to the specified diagnosis or problem which characterises the population) under consideration share some common characteristic but differ in other ways, such as age, gender or in the nature of the disorder (for example a common behavioural problem; acute versus chronic presentations of the same disorder)
- The interventions under consideration in the view of the GDG have one or more of the following characteristics:
    - Share a common mode of action (for example the pharmacodynamics of â€¨drug; a common psychological model of change – operant conditioning)
    - Be feasible to deliver in both populations (for example in terms of the â€¨required skills or the demands of the health care system)
    - Share common side effects/harms in both populations
- The context or comparator involved in the evaluation of the different data sets shares some common elements which support extrapolation
- The outcomes involved in the evaluation of the different data sets shares some common elements which support extrapolation (for example improved mood or a reduction in challenging behaviour)

When the choice of the non-primary data set was made, the following principles were used to guide the application of extrapolation:

- The GDG should first consider the need for extrapolation through a review of the relevant primary data set and be guided in these decisions by the principles for the use of extrapolation
- In all areas of extrapolation data sets should be assessed against the principles for determining the choice of data sets. In general, the criteria in the four principles set out above for determining the choice should be met
- In deciding on the use of extrapolation, the GDG will have to determine if the extrapolation can be held to be reasonable, including ensuring that:
    - The reasoning behind the decision can be justified by the clinical need for a â€¨recommendation to be made
    - The absence of other more direct evidence, and by the relevance of the â€¨potential data set to the review question can be establishedâ€¨
    - The reasoning and the method adopted is clearly set out in the relevant section of the guideline

Method Used to Answer a Review Question in the Absence of Appropriately Designed, High-Quality Research

In the absence of appropriately designed, high-quality research, or where the GDG were of the opinion (on the basis of previous searches or their knowledge of the literature) that there were unlikely to be such evidence, an informal consensus process was adopted. The process involved a group discussion of what is known about the issues. The views of GDG were synthesised narratively, and circulated after the meeting. Feedback was used to revise the text, which was then included in the appropriate evidence review chapter.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Presentation of Economic Evidence

The economic evidence considered in the guideline is provided in the respective evidence chapters, following presentation of the relevant clinical

evidence. The references to included studies and the respective evidence tables with the study characteristics and results are provided in Appendix 20 of the full version of the guideline. Methods and results of economic modelling undertaken alongside the guideline development process are presented in the relevant evidence chapters. Characteristics and results of all economic studies considered during the guideline development process (including modelling studies conducted for this guideline) are summarised in economic evidence profiles accompanying respective Grading of Recommendations Assessment, Development and Evaluation (GRADE) clinical evidence profiles in Appendix 18 of the full version of the original guideline.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was validated through two consultations.

1. The first draft of the guideline (the full guideline and National Institute for Health and Clinical Excellence [NICE] guideline) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG).
2. The final consultation draft of the full guideline, the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate recognition, intervention and management of antisocial and conduct behaviours in children and young people, resulting in improved behaviour and health-related quality of life

Potential Harms

- For the provision of treatment and the organisation and delivery of services, the importance of respecting (and not blaming or stigmatising) parents also emerged. A lack of respect was seen as a key reason for children and young people and their parents or carers withdrawing from treatment.
- Side effects of risperidone include:
    - Metabolic (including weight gain and diabetes)
    - Extrapyramidal (including akathisia, dyskinesia and dystonia)
    - Cardiovascular (including prolonging the QT interval)
    - Hormonal (including increasing plasma prolactin)

Qualifying Statements

Qualifying Statements

- This guidance represents the view of National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.
- Service users and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If someone does not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.
- Some recommendations in this guideline have been adapted from recommendations in other NICE clinical guidance. In these cases the Guideline Development Group was careful to preserve the meaning and intent of the original recommendations. Changes to wording or structure were made to fit the recommendations into this guideline.
- For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision.
- The guideline assumes that prescribers will use a drug's summary of product characteristics to inform decisions made with individual service users.
- This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The service user (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

Implementation of the Guideline

Description of Implementation Strategy

The National Institute for Health and Clinical Excellence (NICE) has developed tools to help organizations implement this guidance (see http://guidance.nice.org.uk/CG158 [see also the "Availability of Companion Documents" field]).

Key Priorities for Implementation

The following recommendations have been identified as priorities for implementation.

Initial Assessment of Children and Young People with a Possible Conduct Disorder

For the initial assessment of a child or young person with a suspected conduct disorder, consider using the Strengths and Difficulties Questionnaire (completed by a parent, carer or teacher).

Assess for the presence of the following significant complicating factors:

- A coexisting mental health problem (for example, depression, post-traumatic stress disorder)
- A neurodevelopmental condition (in particular attention deficit hyperactivity disorder [ADHD] and autism)
- A learning disability or difficulty
- Substance misuse in young people

Comprehensive Assessment

The standard components of a comprehensive assessment of conduct disorders should include asking about and assessing the following:

- Core conduct disorders symptoms including:
  - Patterns of negativistic, hostile, or defiant behaviour in children aged under 11 years
  - Aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules in children aged over 11 years
- Current functioning at home, at school or college and with peers
- Parenting quality
- History of any past or current mental or physical health problems

Parent Training Programmes

Offer a group parent training programme to the parents of children and young people aged between 3 and 11 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or
- Are in contact with the criminal justice system because of antisocial behaviour

Foster Carer/guardian Training Programmes

Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or
- Are in contact with the criminal justice system because of antisocial behaviour

Child-focused Programmes

Offer group social and cognitive problem-solving programmes to children and young people aged between 9 and 14 years who:

- Have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
- Have oppositional defiant disorder or conduct disorder or
- Are in contact with the criminal justice system because of antisocial behaviour

Multimodal Interventions

Offer multimodal interventions, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder.

Pharmacological Interventions

Offer methylphenidate or atomoxetine, within their licensed indications, for the management of ADHD in children and young people with oppositional defiant disorder or conduct disorder (see the NGC summary of the NICE guideline Attention deficit hyperactivity disorder: diagnosis and management [NICE clinical guideline 72]).

Improving Access to Services

Provide information about the services and interventions that constitute the local care pathway, including the:

- Range and nature of the interventions provided
- Settings in which services are delivered
- Processes by which a child or young person moves through the pathway
- Means by which progress and outcomes are assessed
- Delivery of care in related health and social care services

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Collaborating Centre for Mental Health. Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. 47 p. (Clinical guideline; no. 158).

Adaptation

A number of recommendations in this guideline have been adapted from recommendations in other National Institute of Health and Clinical Excellence (NICE) clinical guidelines:

- Attention deficit hyperactivity disorder. See the NGC summary of the NICE guideline Attention deficit hyperactivity disorder: diagnosis and management (NICE clinical guideline 72).
- Antisocial personality disorder. See the NICE guideline Antisocial personality disorder. Treatment, management and prevention (NICE clinical guideline 77).
- Autism diagnosis in children and young people. See the NGC summary of the NICE guideline Autism. Recognition, referral and diagnosis of children and young people on the autism spectrum (NICE clinical guideline 128).

Date Released

2006 Jul (revised 2013 Mar)

Guideline Developer(s)

National Guideline Alliance - National Government Agency [Non-U.S.]

Social Care Institute for Excellence (SCIE) - Nonprofit Research Organization

Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group Members: Stephen Scott *(Chair)*, Professor of Child Health and Behaviour, Institute of Psychiatry, King's College London, Consultant Child and Adolescent Psychiatrist and Head, National Conduct Problems Clinic and National Adoption and Fostering Clinic, Maudsley Hospital, London, Director, Multidimensional Treatment Foster Care Project in England, Director, National Academy for Parenting Research; Nick Gould *(Deputy Chair, representing the Social Care Institute for Excellence)*, Consultant, Social Care Institute for Excellence; Emeritus Professor of Social Work, University of Bath; Professor of Social Work, Griffith University, Queensland, Australia; Stephen Pilling *(Facilitator)*, Director, National Collaborating Centre for Mental Health, Director, Centre for Outcomes Research and Effectiveness, University College London, Professor of Clinical Psychology and Clinical Effectiveness, University College London; Beth Anderson, Senior Research Analyst, Social Care Institute for Excellence, London; Sara Barratt Consultant Systemic Psychotherapist, Team Leader, Fostering, Adoption and Kinship Care Team, Tavistock Centre, London; Maria Brewster, Service user and carer representative; Barbara Compitus, General Practitioner, Bristol; Moira Doolan, Consultant Systemic Psychotherapist, Lead for interventions: HCA and Safe Studies National Academy for Parenting Research, Institute of Psychiatry, Kings College London; Peter Fonagy, Chief Executive, Anna Freud Centre, Freud Memorial, Professor of Psychoanalysis, University College London; Daphne Keen Consultant Developmental Paediatrician, St George's Hospital, London Honorary Senior Lecturer, St George's , University of London; Paul McArdle, Consultant and Senior Lecturer Child and Adolescent Psychiatry, Newcastle; Paul Mitchell, Clinical Lead, Hindley Young Offenders Institution Mental Health Team, Manchester; Jenny Taylor, Consultant Clinical Psychologist, Supervisor of the Hackney site of the Department of Health's Multi-Systemic Therapy National Research Trial; Philippa Williams, Service user and carer representative; Tony Wootton, Retired Head Teacher, Millthorpe School, York

Financial Disclosures/Conflicts of Interest

To minimise and manage any potential conflicts of interest, and to avoid any public concern that commercial or other financial interests have affected the work of the Guideline Development Group (GDG) and influenced guidance, members of the GDG must declare as a matter of public record any interests held by themselves or their families which fall under specified categories (see below). These categories include any relationships they have with the healthcare industries, professional organisations and organisations for people with conduct disorders in children and young people and their families/carers.

Individuals invited to join the GDG were asked to declare their interests before being appointed. To allow the management of any potential conflicts of interest that might arise during the development of the guideline, GDG members were also asked to declare their interests at each GDG meeting throughout the guideline development process. The interests of all the members of the GDG are listed below, including interests declared prior to appointment and during the guideline development process.

The interests of all the members of the GDG are listed in Appendix 2 of the full version of the original guideline, including interests declared prior to appointment and during the guideline development process.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: National Institute for Health and Clinical Excellence (NICE). Parent-training/education programmes in the management of children with conduct disorders. London (UK): National Institute for Health and Clinical Excellence (NICE); 2006 Jul. 49 p.

(Technology appraisal guidance; no. 102).

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site .

Availability of Companion Documents

The following are available:

- Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management. Full guideline. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. 563 p. (Clinical guideline; no. 158). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .
- Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management. Appendices. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. (Clinical guideline; no. 158). Electronic copies: Available in PDF from the NICE Web site .
- Antisocial behaviour and conduct disorders in children and young people. Baseline assessment tool. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. (Clinical guideline; no. 158). Electronic copies: Available in from the NICE Web site .
- Antisocial behaviour and conduct disorders in children and young people: comprehensive assessment and interventions. Clinical audit tool. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. (Clinical guideline; no. 158). Electronic copies: Available in from the NICE Web site .
- Antisocial behaviour and conduct disorders in children and young people. Costing report, London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. 44 p. (Clinical guideline; no. 158). Electronic copies: Available in PDF from the NICE Web site .
- Antisocial behaviour and conduct disorders in children and young people. Costing template. National Institute for Health and Clinical Excellence (NICE); 2013 Mar. (Clinical guideline; no. 158). Electronic copies: Available in from the NICE Web site .
- Antisocial behaviour and conduct disorders in children and young people overview. NICE Pathways. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. (Clinical guideline; no. 158). Electronic copies: Available from the NICE Web site .
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. Electronic copies: Available in Portable Document Format (PDF) from the NICE Archive Web site .

Patient Resources

The following is available:

- Antisocial behaviour and conduct disorders in children and young people. Information for the public. London (UK): National Institute for Health and Clinical Excellence (NICE); 2013 Mar. Available from the National Institute for Health and Clinical Excellence (NICE) Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI on March 9, 2007. This summary was updated by ECRI Institute on June 5, 2013. This summary was updated by ECRI Institute on April 7, 2014 following the U.S. Food and Drug Administration advisory on Methylphenidate ADHD

Medications. This summary was updated by ECRI Institute on July 23, 2015 following the U.S. Food and Drug Administration advisory on the Daytrana Patch (methylphenidate transdermal system).

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